

EYE PHYSICIANS OF CENTRAL FLORIDA  
A Division of Florida Pediatric Associates, LLP  
Leaders in Pediatric and Adult Eye Care

**PATIENT REGISTRATION**

Today's Date: \_\_\_\_\_ Account #: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_ Sex: \_\_\_F\_\_\_M Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First M

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

If patient is a minor: Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**SPOUSE OR PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First M

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work / Cell Phone: \_\_\_\_\_

**REFERRING DOCTOR/PRIMARY DOCTOR INFORMATION**

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRIMARY INSURANCE**

Primary Insurance: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy/ID #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder SS #: \_\_\_\_\_ Policy Holder D.O.B.: \_\_\_/\_\_\_/\_\_\_

Policy Holder Employer: \_\_\_\_\_

**SECONDARY INSURANCE**

Secondary Insurance: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy/ID #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy holder SS #: \_\_\_\_\_ Policy Holder D.O.B.: \_\_\_/\_\_\_/\_\_\_

**EMERGENCY INFORMATION**

Please list a friend or relative (not of the same address) to contact in case of any emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First M

Address: \_\_\_\_\_  
Street City State Zip

Day time Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize **Eye Physicians of Central Florida** to release any medical information necessary to process health insurance claims. \_\_\_\_\_ INITIALS

**ASSIGNMENT OF HEALTH INSURANCE BENEFITS**

I authorize payment of medical benefits applicable to services cited on the claim form to **Eye Physicians of Central Florida**. \_\_\_\_\_ INITIALS

**CONSENT FOR TREATMENT**

This consent is valid during the entire term of my association with **Eye Physicians of Central Florida** and may be relied upon by **Eye Physicians of Central Florida**, unless, and until, revoked by patient or those acting for patient, in writing. Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician (s) in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office. If a biopsy is deemed necessary, I hereby authorize **Eye Physicians of Central Florida** to send a biopsy specimen to a suitable laboratory for a pathology report.

\_\_\_\_\_ INITIALS

**GUARANTEE OF ACCOUNT**

I hereby authorize **Eye Physicians of Central Florida** to provide such information as may be required by state or federal agencies or my insurance company, and for and in consideration of the services rendered to patient, we, the undersigned, jointly or severally, promise to pay to **Eye Physicians of Central Florida** the full amount of charges for such services, on demand, or by such future date as may be determined by **Eye Physicians of Central Florida**. I understand that my bill will be due and payable in full on or before such date. In the event of default, I agree to pay a reasonable attorney fee and costs.

\_\_\_\_\_ INITIALS

**REFRACTIONS**

Refractions are not a covered benefit under most medical insurance plans. **The cost for refraction is \$70 and will be collected at the time of service.** A refraction enables the doctor to determine whether glasses are necessary or need to be changed. It is an essential part of a complete eye exam from infants to adults. \_\_\_\_\_ INITIALS

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship \_\_\_\_\_